



Introduction to: Unequal care: Trans medicine and health in dangerous times

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This special issue was conceived as an intervention into troubling trends in trans medicine. As recent news coverage accentuates, trans medicine is under increasing attacks by legislators and anti-trans activists. These mobilizations are supported by well-organized misinformation campaigns (McNamara et al., 2024; Wuest and Last, 2024a) that seek to undermine trans people, medical professionals, and gender itself. But while scholars have begun to address these attacks on gender-affirming care for trans youth, there are other forces afoot challenging trans people's ability to enter, and engage with, health encounters and medical infrastructures with self-determination and bodily autonomy. It is not coincidental that recent efforts to undermine trans people's access to care and bodily autonomy are occurring at the same time that reproductive rights, healthcare provider autonomy, and the legitimacy of medical science is being chipped away by conservative forces (Wang et al., 2019). We must understand these trends as concerted, intentional, and dangerous efforts to undermine science, medicine, and marginalized people's access to healthcare and other social institutions.

Despite growing public awareness of trans and nonbinary people and medical associations seeking to create more affirming spaces, there remain lingering issues within the field. Durable inequities further undermine the structure and practice of trans medicine including normative values ascribed to trans people's reproductive health (Pfeffer et al., 2023), ignorance about how to work with trans people because of historical and contemporary uncertainties that beleaguer medical professionals (Shuster, 2021), and new health information technologies and professional practices that are counterproductive to recognizing and addressing civil rights violations and accurately tracking and recording trans and nonbinary people's identities (Kirkland, 2021).

1. What is wrong with trans medicine?

Given the multifaceted elements of inequality and oppression from within and outside of trans medicine, this special issue is provoked by the overarching question: What is wrong with trans medicine and how can we fix it?

Just as there are broader social forces that present challenges to trans

medicine, so too do limitations within the scholarship on trans medicine and health. Most existing studies in social sciences focus on health outcomes rather than health processes, which flattens the potential to theorize *why and how* inequalities continue, expand, or retract. Moreover, scholars have long called for intersectional and longitudinal analyses, but rarely are able to offer such analytic interventions because of small sample sizes, measurement issues in pre-existing surveys, and difficulty obtaining funding for their research (Hart et al., 2019). While studies of trans medicine and health must certainly be situated within their particular social and cultural contexts, most published and cited research remains centered in the Global North, limiting possibilities for considering both the commonalities and particularities that exist across trans medicine and health experiences, as well as what might be learned and gained from more expansive or cross-cultural explorations (Lynne-Joseph, 2024). In addition, much existing research on trans medicine and health experiences focuses on barriers to care, health problems, and suicide (Hsieh and Shuster, 2021), reflecting a pattern of what Shuster and Westbrook (2024) have described as a "joy deficit," and failing to highlight the many forms of strength, power, resilience, and resistance that trans and nonbinary individuals and communities enact. Further, scholars of trans medicine and health rarely look to the intersection of other institutions such as immigration, legal jurisprudence, or science and technology, even though these institutions influence health and medicine. Political scientists and law and political economy scholars argue that we need structural-level understandings of inequality linked to policies and governance (Lynch, 2019, 2023; Wuest and Last, 2024b). On this view, it is too narrow to focus on healthcare encounters or mechanisms like unconscious bias from healthcare professionals. Civil rights protections for trans healthcare often fail at multiple levels (i.e. the hospital, the insurance company, and the state) because our relatively weak rights protections are overwhelmed and defeated by the economic, political, and legal power relations in healthcare systems (Kirkland, 2025; Kirkland and Hyman, 2021). Trans studies has grown more in the humanities than in the social sciences. But because of different theoretical lineages and, sometimes, limited methodological opportunities and choices, there can be a lack of conversation between scholars of trans medicine from the humanities and social

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<https://doi.org/10.1016/j.socscimed.2024.117272>

sciences.

Differences in language across the humanities and social sciences, and within fields of inquiry, can make it difficult to parse ‘best’ practices in terminology. As special issue editors, we did not standardize the language used by contributors because of differences across communities, discipline, culture, and/or country of origin (Farber, 2023). Some guidance suggests “gender diverse,” others recommend “trans and nonbinary,” and still other combinations exist such as “gender variant people” (Bouman et al., 2017). Within the social study of medicine, scholars may use “gender-affirming,” “trans medical interventions,” or “trans care.” Even within trans activist and community spaces, these conversations are unsettled (Pearce et al., 2019), as there are political stakes in the language used and the symbolic conveyances of selecting one phrase over another. In response, each contributor to the special issue was asked to think carefully about the language used in their writing practices, and to reflect the language used by the groups they were working with.

While there are considerable problems within trans medicine and its empirical study, this special issue offers the potential to shift conversations, sites of inquiry, and our methodological and theoretical approaches. Scholars who appear in this special issue are taking theoretical risks, employing methodological and theoretical approaches rarely used in trans health and medicine research, and making urgently needed linkages between trans medicine and other aspects of the social study of medicine.

To the best of our knowledge, there are few existing anthologies or special issues that bring together such an ambitious array of authors, topics, methods, and theories. The authors in the special issue offer findings that extend our understanding of both the potentials and limitations of activist movements by showing how DIY movements are springing up in response to barriers to healthcare. Some authors are redefining conceptions core to the social study of medicine—including those focusing on “risk” and “health” itself. Others are demonstrating how the sociopolitical landscape of trans medicine is not an outlier field of study but, rather, is a canary in the coalmine for anticipating future restrictive policymaking. By tackling such a broad array of topics, the authors in this special issue offer demonstrable evidence that trans medicine and health is a lively field that expands conversations central to the study of health and medicine. Importantly, several of the papers appearing in the special issue respond to calls for scholars of medicine to disband the practice of focusing solely on the US and/or Global North. Scholarship appearing in this issue from the Global South offers new perspectives on how cultural contexts shape local practice, alternate models of healthcare, and worrisome trends in the robustness of health inequities tracing across the Global South and North.

2. Organization of the special issue

While the volume of papers appearing in the special issue is ambitious, they share several uniting threads. We organized the special issue into three separate themes that represent innovative scholarship in trans medicine and health: 1) Emergent inequities in trans medicine; 2) Social and legal construction of medical knowledge, practices, and culture in trans medicine; and 3) Mobilizing patient experiences and embodied knowledge.

2.1. Emergent inequities in trans medicine

Authors in the special issue afford new methodological and theoretical tools to advance knowledge of how and why inequalities persist in trans medicine. Despite the study of trans medicine and health growing in the last decade, a significant portion of studies lean on Minority Stress Theory (MST). This is for good reason, as scholarship in this area (e.g. Hendricks and Testa, 2012; Meyer, 2003) has offered important insights into the multiple layers of stressors that trans and nonbinary people confront. Nonetheless, Linander, Lundberg, and Alm’s

(2024) article offers a critical perspective on the limitations of MST and how because of canon-building practices in the field, theory development has stagnated as MST became an over-utilized or default theory in the field that explains everything at the risk of offering relatively little new knowledge.

Methodologically, the scholarship on trans health and medicine tends to bifurcate between population health (which tends toward secondary analyses of existing large-scale datasets) and interview-based studies (which tends toward “small n” original studies). Many of both types of studies have become repetitious, documenting similar experiences and population-level outcomes. Novelty comes through specifying differences within the category of trans. There is little theoretical engagement in these brief empirical studies. It is necessary to document patterns and variations, but after a certain amount of saturation these studies may not move the field forward beyond descriptive updating. Kiely et al. (2024) introduce a novel comparative analytic approach, that accounts for system-level measures such as health provision, regulation, and access as well as country-level measures including socio-political climates, to examine trans-specific healthcare systems across 28 European countries. They offer a typology of trans-specific health systems and demonstrate the methodological value of cross-country comparative analyses to account for geographically uneven care availability, access, and provision, as well as outcomes of health inequities.

To advance theories and knowledge, several authors in the special issue shift away from trans medicine as a niche field (Shuster, 2020) by making connections between what the case of trans medicine might offer to the broader social study of medicine and health. While much scholarship in trans medicine focuses explicitly on gender-affirming care (including hormones and surgical interventions), some scholars are turning to other areas of medicine to expand the scope of inquiry to not only trans-specific interventions, but how trans people encounter various sectors of medicine *beyond* gender-affirming care. Hughto et al. (2024) highlight how substance use care professionals have lasting gaps in knowledgeably caring for trans and gender diverse populations. Some employed a “gender blind” approach, maintaining that the gender of their clients is inconsequential to the care they receive.

Yet such an approach tends to render trans experience within health encounters invisible, as Marrow et al.’s (2023) systematic review of scholarship on intimate partner violence (IPV) demonstrates. They offer a meta-analysis of theoretical explanations for why IPV occurs and begin with the premise that most IPV scholarship is undergirded by cisnormativity, wherein cisgender men exercise power and control over cisgender women. The authors propose upending this well-worn trope by offering a model that, instead, can account for experiences with IPV that do not rely upon binary and dichotomous systems of gender.

Finding knowledgeable, competent, and compassionate providers are durable barriers to quality care for trans and nonbinary people. Smith and Harrop (2024) study trans adults with eating disorders and found that they have unmet healthcare needs. Because of anti-weight stigma and binarism, trans patients continue to experience health inequities – even by gender-affirming providers – because these providers are often not equipped with the training and tools to think of trans people beyond gender-affirming care. Atuk’s (2024) ethnographic study examines the medical experiences of HIV-positive trans women in Turkey who are treated as always-already infectious by providers who are reluctant to examine, touch, or admit trans patients into care clinics. The downstream consequences of treating trans people as “contagious others” is a form of slow-motion violence, wherein trans women—especially those who are HIV positive—are left untreated, stigmatized, and at risk of death.

A partial explanation for why there remains a gap in knowledgeable, competent, and compassionate providers may be found in the building blocks of knowledge acquisition – medical school. Yet medical school curricula have a gender problem. Kelley’s (2024) study draws on focus groups to examine how gender-diverse medical students experience

medical school and finds that because of the normative values influencing medical school curricula, it is not only lack of *content* about trans people and healthcare that is a problem, but the *organizational context* of medical school, which creates a hostile learning environment for trans and gender-diverse medical students.

Moreover, even when providers are intentionally creating inclusive health spaces, countervailing forces (Light, 2010) contribute to inertia around progressive change. Zhou's (2024) study examines the relationship between global health guidance and local contexts that create contradictory practices in trans medicine in China. They find that while medical providers embrace a more inclusive approach by drawing on global health guidance in a shift toward patient-centered models of care, providers simultaneously reinforce gatekeeping by calling upon family members to become involved in gender-affirming care. In so doing, providers unintentionally reinforce gatekeeping that is both restrictive and affective in its dimensions.

2.2. Social and legal construction of medical knowledge, practices, and culture in trans medicine

Professional documents such as diagnostic codes and clinical guidelines represent formalized knowledge by medical and scientific experts that also convey tacit cultural assumptions about norms, values, and "respectable" gender expression and identity (Shuster, 2021). Activists have long called upon the World Professional Association of Transgender Health (WPATH) to upend such assumptions (Riggs et al., 2019) that undergird the Standards of Care, or guidelines, for working with trans people. Lynne-Joseph (2024) offers a rich, ethnographic, multi-site study of Thailand and the US to examine how, despite calls from activists, the newest version (8) of the WPATH Standards of Care continues to reproduce knowledge that relies upon professional expertise while sidelining or ignoring lay expertise, especially from the Global South. Alongside calls for trans and nonbinary people's voices and expertise to be accounted for in the WPATH Standards of Care, trans and nonbinary people have also advocated for decoupling diagnostic codes from psychiatric pathologization (Riggs et al., 2019). The hope is that, in so doing, being trans or nonbinary will no longer be perceived as symptomatic of a psychiatric illness. Primdahl and Tellerup (2023) examine political discourse in Denmark in the years leading up to 2017, when gender dysphoria was reclassified as a non-psychiatric diagnosis. They found that, despite reclassification and the shift toward a liberal rights approach, gender essentialism was maintained.

The durability of gender essentialism and binarist thinking may be found in language itself, which tends to reinforce ideas about who counts in medical and scientific infrastructures. For example, previous scholarship (Boellstorff, 2011) demonstrates how public health officials' attempts to shift language practices away from sexual identity (e.g. gay men) and toward behavior-focused language (e.g. men who have sex with men (MSM)) have expanded opportunities for HIV-prevention interventions among some people, but to the exclusion of others. Pignedoli and Rivest (2024) examine the spillover effects of such efforts in French HIV prevention campaigns to direct MSM to pre-exposure prophylaxis (PrEP). Because of the structure of language and reigning assumptions about who "should" use PrEP, trans men are consistently left out of such campaigns, to their detriment.

Because of historical and contemporary uncertainties in the state of scientific evidence in trans medicine (Shuster, 2021), politicians are emboldened to lean on such uncertainty to advocate for gender-affirming care bans. Wuest and Last (2024a) demonstrate how "agents of uncertainty," including scientists, clinicians, and politicians, mobilize uncertainty to restrict gender-affirming care and pursue successful court cases. Part of their ability to mobilize uncertainty rests on the widespread misinformation campaigns that have come to dominate the policy landscape of gender-affirming care. McNamara et al. (2024) analyze five legal cases in the US that seek to ban gender-affirming care for youth. The authors confirm that widespread scientific disinformation

catalyzes recent court cases, which has dire consequences for trans and nonbinary people, especially youth. They conclude that the precedent that is being set will have far-reaching spillover effects on medical policy beyond GAC. Despite there being mixed results to ban gender-affirming care altogether in the US, Noralla (2024) turns our attention to Islamic Sharia-influenced policy in Egypt that also attempts to ban gender-affirming care. Grassroots mobilizations, including do-it-yourself (DIY) hormones and underground medical clinics, are innovative tactics used by some trans and nonbinary people to work-around existing restrictive health policy and bans on gender-affirming care.

2.3. Mobilizing patient experiences and embodied knowledge

Contributors to the special issue consistently find that while there remain massive gaps in provider knowledge and issues with access to high-quality, ethical care, trans and nonbinary people are claiming power back with innovative technologies and DIY grassroots movements. Trans technologies can offer vital resources for trans people to find providers and health information; especially in an infodemic of misinformation. Drawing on interviews with creators of trans technologies, Everhart et al. (2024) found that a central goal of trans technologists is to increase access to gender-affirming care by creating technological possibilities for sharing information and building community. But there are limitations with these technologies. For example, in the US, these technologies tend to be directed toward people living in coastal areas in the East and West, leaving a relative vacuum across other regions of the country.

Despite limitations of trans technologies to fully counter gaps in knowledge and facilitate information sharing, trans and nonbinary people are finding additional ways to work around inequities in health infrastructures. For example, Jordan's (2024) interview study with transmasculine adults in Los Angeles County uses an intersectional analysis to explore how low-income trans people of color contest medical authority and claim back power through *compelling care*, or community-based health equity interventions. Similarly, Kia et al. (2023) document the importance of peer support as trans and nonbinary people navigate health encounters, make decisions, and resist healthcare inequities. Blus-Kadosh and Hartal (2024) interview trans people and medical professionals in Israel and find a breadth of trans-exclusionary practices within primary care and family medicine. Despite this, trans people galvanize community resources and experiential knowledge to overcome obstacles embedded across multiple levels of the medical establishment and accumulate resources to push back against biopower. But experiential knowledge that is self-empowering for activists is also, unfortunately, dismissed by many in the medical establishment, creating limitations for long-lasting institutional and cultural change.

A question with which many marginalized people grapple is: What makes life livable (Butler, 2004)? For some trans and nonbinary people, access to hormones is a necessary, but difficult to attain, part of the equation in answering such a question. August-Rae et al. (2024) find that in response to accumulating mistrust in the medical system, driven in part by barriers to accessing care, some trans people engage in DIY hormone access and administration practices, organize online to teach others these practices and, in the process, empower one another to have more agency over their bodies, health, and lives.

DIY movements are not limited, of course, to the US. As Wang (2024) demonstrates, medical gatekeeping practices in China box many trans people into situations where they must utilize DIY hormone therapies to access the care they need. Wang's (2024) work shows how community knowledge sharing and reconceptualizing ideas of risk and toxicity can facilitate reimagining and reconfiguring access to care. But it is critical not to romanticize DIY movements and to carefully consider both their limitations and the social conditions under which they emerge. Wardell and Withey-Rila's (2024) study of medical crowdfunding in New Zealand highlights how trans visibility through crowdfunding sites may

offer financial resources for (some) trans people, but also increases risks associated with being out and reinforces transnormativity as trans people make their bodies and stories intelligible to a broader public audience, on whom they depend, in order to successfully raise funds for needed medical care.

3. Conclusion

We wish to warmly thank Stefan Timmermans, Rebecca Kaufman, Alexandra Brewis, and Karen Lutefey Spencer for their exceptionally helpful guidance in creating this special issue. We are indebted to the 86 reviewers who generously offered their time, expertise, and generative comments for the authors. Because our hope was to have the articles that appear in the special issue speak back to broader areas in the social study of medicine, reviewers came from the humanities and social sciences, represented a breadth of expertise that extended beyond trans studies, and theoretical and methodological orientations.

Across these articles, every author identifies a vital need for social scientists to think together through these troubling and enduring issues in the state of scholarship in trans medicine and healthcare. This special issue offers new opportunities for scholars to examine both persistent and emergent inequalities in trans medicine with an eye toward potential solutions. Each contributor offers new insights, tools, policy recommendations, and theories for scholars of the social study of medicine to apply to other fields of medicine and across disciplines and institutions. They demonstrate that in grappling with trans medicine in dangerous times trans people and (sometimes) healthcare professionals can find ways to claim power back in important and creative ways in proactive response to structural oppression.

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